StayHealthy

MEDICAL REPORT

Patient Name _____

DOB _____

Age _____

Nationality _____

Sex *(Gender)* _____

Blood Pressure _____

Pulse _____

Temperature _____

Skin _____

Conclusion _____

_____

_____

This is to certify that Mr /Ms / Mrs _____

was diagnosed in _____

(insert the name of the medical facility)* on _____ *(insert date)

Doctor's name _____

Doctor's Signature _____

Doctor / Medical Facility Stamp